		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044602

Facility Name: OAK PARK HEALTHCARE CENTER

Address: 625 N HARLEM (Number) OAK PARK (City) 60302 (Zip Code)

County: COOK

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-4303161

Date of Initial License for Current Owners: 11/01/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SHERWIN I. RAY

(Title) MANAGER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	176	Skilled (SNF)	176	64,240	1
2		Skilled Pediatric (SNF/PED)			2
3	28	Intermediate (ICF)	28	10,220	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	204	TOTALS	204	74,460	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,798	1,798	8
9	SNF/PED					9
10	ICF	54,265	1,655		55,920	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	54,265	1,655	1,798	57,718	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.52%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 1,798

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	195,833	29,309	14,247	239,389		239,389	2,358	241,747			1
2	Food Purchase		253,743		253,743	(15,002)	238,741	(819)	237,922			2
3	Housekeeping	145,486	29,866	0	175,352		175,352	0	175,352			3
4	Laundry	67,011	16,718	0	83,729		83,729	0	83,729			4
5	Heat and Other Utilities			132,486	132,486		132,486	644	133,130			5
6	Maintenance	58,080	20,740	44,147	122,967		122,967	10,834	133,801			6
7	Other (specify):*			12,874	12,874		12,874	0	12,874			7
8	TOTAL General Services	466,410	350,376	203,754	1,020,540	(15,002)	1,005,538	13,017	1,018,555			8
	B. Health Care and Programs											
9	Medical Director	0		500	500		500	0	500			9
10	Nursing and Medical Records	1,880,115	80,163	27,929	1,988,207		1,988,207	28,605	2,016,812			10
10a	Therapy	67,894	31,185	40,380	139,459		139,459	10,279	149,738			10a
11	Activities	77,390	8,228	0	85,618		85,618	0	85,618			11
12	Social Services	102,432		4,651	107,083		107,083	0	107,083			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			133	133		133	0	133			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	2,127,831	119,576	73,593	2,321,000	0	2,321,000	38,884	2,359,884			16
	C. General Administration											
17	Administrative	96,079		0	96,079		96,079	58,753	154,832			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			258,065	258,065		258,065	(206,163)	51,902			19
20	Dues, Fees, Subscriptions & Promotions			46,383	46,383		46,383	(6,880)	39,503			20
21	Clerical & General Office Expenses	93,702	15,443	179,718	288,863		288,863	(80,185)	208,678			21
22	Employee Benefits & Payroll Taxes			423,373	423,373	15,002	438,375	0	438,375			22
23	Inservice Training & Education			0	0		0	557	557			23
24	Travel and Seminar			885	885		885	587	1,472			24
25	Other Admin. Staff Transportation			66	66		66	2,675	2,741			25
26	Insurance-Prop.Liab.Malpractice			110,611	110,611		110,611	5,192	115,803			26
27	Other (specify):*			0	0		0	44,180	44,180			27
28	TOTAL General Administration	189,781	15,443	1,019,101	1,224,325	15,002	1,239,327	(181,284)	1,058,043			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,784,022	485,395	1,296,448	4,565,865	0	4,565,865	(129,383)	4,436,482			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER #0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			37,722	37,722		37,722	(7,379)	30,343			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			154,260	154,260		154,260	19,902	174,162			32
33	Real Estate Taxes			306,135	306,135		306,135	0	306,135			33
34	Rent-Facility & Grounds			1,125,731	1,125,731		1,125,731	7,542	1,133,273			34
35	Rent-Equipment & Vehicles			40,867	40,867		40,867	(11,432)	29,435			35
36	Other (specify):*				0		0	0	0			36
37	**TOTAL Ownership**			1,664,715	1,664,715	0	1,664,715	8,633	1,673,348			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		88,801	32,801	121,602		121,602	(7,900)	113,702			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			111,690	111,690		111,690	0	111,690			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	88,801	144,491	233,292	0	233,292	(7,900)	225,392			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,784,022	574,196	3,105,654	6,463,872	0	6,463,872	(128,650)	6,335,222			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,317)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(819)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(256)	20		17
18	Fines and Penalties	(25,417)	21		18
19	Entertainment				19
20	Contributions	(2,899)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(7,666)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,141)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(21,665)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (79,180)		$ 0	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(49,470)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (49,470)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (128,650)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

OAK PARK HEALTHCARE CENTER

ID# 0044602

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ (1,682)	6	1
2	MARKETING SALARIES	(19,983)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(21,665)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	2,358	0	0	0	0	0	0	0	0	0	2,358	1
2	Food Purchase	(819)	0	0	0	0	0	0	0	0	0	0	(819)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	644	0	0	0	0	0	0	0	0	0	644	5
6	Maintenance	(1,682)	12,516	0	0	0	0	0	0	0	0	0	10,834	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,501)	15,518	0	0	0	0	0	0	0	0	0	13,017	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	28,605	0	0	0	0	0	0	0	0	0	28,605	10
10a	Therapy	0	11,302	(1,023)	0	0	0	0	0	0	0	0	10,279	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	39,907	(1,023)	0	0	0	0	0	0	0	0	38,884	16
	C. General Administration													
17	Administrative	0	58,753	0	0	0	0	0	0	0	0	0	58,753	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(206,163)	0	0	0	0	0	0	0	0	0	(206,163)	19
20	Fees, Subscriptions & Promotions	(11,962)	0	5,082	0	0	0	0	0	0	0	0	(6,880)	20
21	Clerical & General Office Expenses	(45,400)	(122,400)	87,615	0	0	0	0	0	0	0	0	(80,185)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	557	0	0	0	0	0	0	0	0	557	23
24	Travel and Seminar	0	0	587	0	0	0	0	0	0	0	0	587	24
25	Other Admin. Staff Transportation	0	0	2,675	0	0	0	0	0	0	0	0	2,675	25
26	Insurance-Prop.Liab.Malpractice	0	0	5,192	0	0	0	0	0	0	0	0	5,192	26
27	Other (specify):*	0	0	44,180	0	0	0	0	0	0	0	0	44,180	27
28	TOTAL General Administration	(57,362)	(269,810)	145,888	0	0	0	0	0	0	0	0	(181,284)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(59,863)	(214,385)	144,865	0	0	0	0	0	0	0	0	(129,383)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(19,317)	0	11,938	0	0	0	0	0	0	0	0	(7,379)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	19,902	0	0	0	0	0	0	0	0	19,902	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	7,542	0	0	0	0	0	0	0	0	7,542	34
35	Rent-Equipment & Vehicles	0	(19,457)	8,025	0	0	0	0	0	0	0	0	(11,432)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(19,317)	(19,457)	47,407	0	0	0	0	0	0	0	0	8,633	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(7,900)	0	0	0	0	0	0	0	0	(7,900)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	(7,900)	0	0	0	0	0	0	0	0	(7,900)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(79,180)	(233,842)	184,372	0	0	0	0	0	0	0	0	(128,650)	45

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT	NILES	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
SEE ATTACHED SCHEDULES					NILES	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	35	COMPUTER LEASE	$ 19,457	CAREPLUS MGMT INC		$	$ (19,457)	1
2	V	19	ADMIN. CONSULTANT FEES	198,000	" "			(198,000)	2
3	V	19	DATA PROCESSING FEES	14,400	" "			(14,400)	3
4	V	21	CLERICAL FEES	122,400	" "			(122,400)	4
5	V	1	DIETARY CONSULTANT FEES	7,200	" "			(7,200)	5
6	V	1	DIETARY SALARIES		" "		9,558	9,558	6
7	V	5	ELECTRICITY		" "		644	644	7
8	V	6	REPAIRS		" "		367	367	8
9	V	6	MAINTENANCE SALARIES		" "		12,149	12,149	9
10	V	10	NURSING		" "		28,605	28,605	10
11	V	10a	THERAPY SALARIES		" "		11,302	11,302	11
12	V	17	ADMIN SALARIES		" "		58,753	58,753	12
13	V	19	PROFESSIONAL FEES		" "		6,237	6,237	13
14	Total			$ 361,457			$ 127,615	$ * (233,842)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	DUES/LICENSES/WANT ADS	$	CAREPLUS MGMT INC		$ 5,082	$ 5,082	15
16	V	21	OFFICE SALARIES/EXPENSES		" "		87,615	87,615	16
17	V	23	SEMINARS		" "		557	557	17
18	V	24	TRAVEL		" "		587	587	18
19	V	25	TRANSPORTATION		" "		2,675	2,675	19
20	V	26	INSURANCE		" "		5,192	5,192	20
21	V	27	EMPLOYEE BENEFITS		" "		44,180	44,180	21
22	V	30	SL DEPRECIATION		" "		11,938	11,938	22
23	V	32	INTEREST		" "		19,902	19,902	23
24	V	34	OFFICE RENT		" "		7,542	7,542	24
25	V	35	EQUIP RENT/AUTO LEASE		" "		8,025	8,025	25
26	V								26
27	V								27
28	V								28
29	V	10a	THERAPY SERVICES	40,705	CAREPLUS REHABILITATIVE SERVICES		39,682	(1,023)	29
30	V	39	ANCILLARY THERAPY	31,599	" "		23,699	(7,900)	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 72,304			$ 256,676	$ * 184,372	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN RAY	PRESIDENT	ADMIN/FINANCI	50.00	SEE ATTACHED	5.7	9.51	SALARY	14,581	17-7	2
3	JAKOB BAKST	DIR OPERAT'NS	ADMIN/CONS.	50.00	SCHEDULES	5.7	9.51	" "	14,581	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 29,162		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT INC
Street Address: 5940 W TOUHY
City / State / Zip Code: NILES 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	506,586	11 HOMES	$ 83,890	$ 83,890	57,718	$ 9,558	1
2	5	ELECTRICITY	" "	606,625	15 HOMES	6,767		57,718	644	2
3	6	REPAIRS	" "	606,625	15 HOMES	3,858		57,718	367	3
4	6	MAINTENANCE SALARIES	" "	606,625	15 HOMES	127,691	127,691	57,718	12,149	4
5	10	NURSING	" "	606,625	15 HOMES	300,646	300,646	57,718	28,605	5
6	10a	THERAPY SALARIES	" "	570,238	13 HOMES	111,658	96,375	57,718	11,302	6
7	17	ADMIN SALARIES	" "	606,625	15 HOMES	617,499	617,499	57,718	58,753	7
8	19	PROFESSIONAL FEES	" "	606,625	15 HOMES	65,550		57,718	6,237	8
9	20	DUES/LICENSES/WANT ADS	" "	606,625	15 HOMES	53,408		57,718	5,082	9
10	21	OFFICE SALARIES/EXPENSES	" "	606,625	15 HOMES	920,855	677,141	57,718	87,615	10
11	23	SEMINARS	" "	606,625	15 HOMES	5,849		57,718	557	11
12	24	TRAVEL	" "	606,625	15 HOMES	6,170		57,718	587	12
13	25	TRANSPORTATION	" "	606,625	15 HOMES	28,114		57,718	2,675	13
14	26	INSURANCE	" "	606,625	15 HOMES	54,564		57,718	5,192	14
15	27	EMPLOYEE BENEFITS	" "	606,625	15 HOMES	464,335		57,718	44,180	15
16	30	SL DEPRECIATION	" "	606,625	15 HOMES	125,471		57,718	11,938	16
17	32	INTEREST	" "	606,625	15 HOMES	209,175		57,718	19,902	17
18	34	OFFICE RENT	" "	606,625	15 HOMES	79,265		57,718	7,542	18
19	35	EQUIP RENT/AUTO LEASE	" "	606,625	15 HOMES	84,343		57,718	8,025	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,349,108	$ 1,903,242		$ 320,910	25

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CAREPLUS MANAGEMENT ALLOCATION: LOC, ETC						$	$			$ 19,902	1
2												2
3	ERIC ROTHNER		X				510,000	510,000			11,029	3
4	CAREPLUS MGMT - CIB BK	X		CAPL IMPR LOAN FEES	5 YR AMORT	2/23/01	2,475	2,062	3/23/06		413	4
5	CAREPLUS MGMT - CIB BK	X		CAPITAL IMPROVEMENT	$10,426.58	2/23/01	495,000	422,779	3/23/06	PRIME+	32,045	5
	Working Capital											
6	CAREPLUS MGMT INC	X		WORKING CAPITAL	DEMAND	Nov-99	1,925,000	1,850,000		PRIME+	105,159	6
7	INSURANCE FINANCING		X	INSUR. FINANCE							5,614	7
8												8
9	TOTAL Facility Related				$10,426.58		$ 2,932,475	$ 2,784,841			$ 174,162	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 2,932,475	$ 2,784,841			$ 174,162	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 288,470	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 295,825	2
3. Under or (over) accrual (line 2 minus line 1).		$ 7,355	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 298,780	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 306,135	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	281,916	8
	1997	286,264	9
	1998	292,508	10
	1999	285,617	11
	2000	295,825	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME OAK PARK HEALTHCARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044602

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-07-106-004-0000	NURSING HOME	$ 58,979.03	$ 58,979.03
2.	16-07-106-005-0000	NURSING HOME	$ 56,436.39	$ 56,436.39
3.	16-07-106-022-0000	NURSING HOME	$ 180,409.33	$ 180,409.33
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 295,824.75	$ 295,824.75

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,926 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2+BASEMENT/ 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	22,950		$	1
2					2
3	TOTALS	22,950		$ 0	3

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	NEW WINDOWS / LIGHT FIXTURES / GENERATOR			1999	74,653	1,914	39	1,914		3,923	9
10	WINDOWS / FENCE / CEILING			2000	13,360	486	27.5	486		952	10
11	WINDOWS / SIGNS / FLOORING / WALLPAPER			2000	43,229	1,572	27.5	1,572		2,919	11
12	WINDOWS /FLOORING /WALLPAPER / NURSE STATION			2000	29,709	1,080	27.5	1,080		1,845	12
13	FLOORING / DOORS /WALLS /HVAC SYSTEM			2000	56,310	2,047	27.5	2,047		3,327	13
14	WINDOWS / FLOORING / RAILS / ASPHALT PAVING			2000	30,160	1,096	27.5	1,096		1,650	14
15	WINDOWS / PLUMBING / PAINTING & DECORATING			2000	41,459	1,508	27.5	1,508		1,896	15
16	WINDOW TREATMENTS			2000	19,213	4,705	15	1,281	(3,424)	1,921	16
17	WINDOWS/WALK-IN FREEZER, ROOF & A/C REPAIRS			2001	23,850	592	27.5	592		592	17
18	WINDOWS//FLOORING/ALARM & PAGING SYSTEM			2001	9,926	38	27.5	38		38	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	RELATED PARTY ALLOCATION - CAREPLUS MGMT					112		112			34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 341,869	$ 15,150		$ 11,726	$ (3,424)	$ 19,063	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 87,731	$ 21,718	$ 6,489	$ (15,229)	8-15 YRS	$ 10,371	71
72	Current Year Purchases	6,762	966	302	(664)	10-15 YRS	302	72
73	Fully Depreciated Assets				0			73
74	** RELATED PARTY - ALLOCATED SL DEPN: CAREPLUS MGMT, 11,826		11,826	11,826	0			74
75	TOTALS	$ 94,493	$ 34,510	$ 18,617	$ (15,893)		$ 10,673	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 436,362	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 49,660	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 30,343	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (19,317)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 29,736	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: FAIRMOUNT OF OAK PARK LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		204	11/01/99	$ 1,103,874			3
4	Additions				21,857			4
5								5
6								6
7	TOTAL		204		$ 1,125,731 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 11/01/99
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2002	$
13.	12/31/2003	$
14.	12/31/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 40,867 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 12,065	$		$ 12,065	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			297			297	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			20,439			20,439	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				61,110		61,110	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-2					11,125		11,125	12
13	MED.SUPPLIES/LAB/RENTALS Other (specify):	39-2					16,566		16,566	13
14	TOTAL			$		$ 32,801	$ 88,801		$ 121,602	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER **#** 0044602 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 189,464	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	983,161		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,160		6
7	Other Prepaid Expenses	11,892		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): R.E.TAX ESCROW	283,122		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,505,799	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	341,869		15
16	Equipment, at Historical Cost	109,457		16
17	Accumulated Depreciation (book methods)	(59,990)		17
18	Deferred Charges	464,705		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 856,041	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,361,840	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 322,913	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,623		28
29	Short-Term Notes Payable	1,850,000		29
30	Accrued Salaries Payable	60,527		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,735		31
32	Accrued Real Estate Taxes(Sch.IX-B)	298,780		32
33	Accrued Interest Payable	73,255		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,630,833	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	932,779		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 932,779	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,563,612	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,201,772)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,361,840	$ 0	48

***(See instructions.)**

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (490,519)	1
2	Restatements (describe):		2
3	**INTEREST EXPENSE**	(54,430)	3
4	**AMORTIZATION OF RENT DEPOSIT**	(25,500)	4
5	**ROUNDING**	(1)	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (570,450)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(631,322)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (631,322)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,201,772)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,765,535	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,765,535	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	67,011	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 67,011	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,832,550	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,020,540	31
32	Health Care	2,321,000	32
33	General Administration	1,224,325	33
	B. Capital Expense		
34	Ownership	1,664,715	34
	C. Ancillary Expense		
35	Special Cost Centers	121,602	35
36	Provider Participation Fee	111,690	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,463,872	40
41	**Income before Income Taxes (line 30 minus line 40)****	(631,322)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (631,322)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN IS PREPARED ON CASH BASIS.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,823	2,021	$ 60,788	$ 30.08	1
2	Assistant Director of Nursing	2,166	2,412	61,812	25.63	2
3	Registered Nurses	29,112	30,310	640,449	21.13	3
4	Licensed Practical Nurses	19,727	21,156	374,499	17.70	4
5	Nurse Aides & Orderlies	79,691	86,767	719,790	8.30	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,546	8,137	67,894	8.34	8
9	Activity Director	2,063	2,128	25,692	12.07	9
10	Activity Assistants	6,729	7,263	51,698	7.12	10
11	Social Service Workers	5,316	5,465	102,432	18.74	11
12	Dietician					12
13	Food Service Supervisor	2,420	2,720	31,936	11.74	13
14	Head Cook	4,632	4,946	46,092	9.32	14
15	Cook Helpers/Assistants	14,394	15,314	117,805	7.69	15
16	Dishwashers					16
17	Maintenance Workers	4,455	4,691	58,080	12.38	17
18	Housekeepers	20,792	21,974	145,486	6.62	18
19	Laundry	9,098	9,938	67,011	6.74	19
20	Administrator	1,619	1,726	58,587	33.94	20
21	Assistant Administrator	1,846	1,934	37,492	19.39	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,104	7,397	73,719	9.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,943	2,155	22,777	10.57	31
32	Other Health Care(specify)					32
33	Other(specify) MARKETING	1,009	1,039	19,983	19.23	33
34	TOTAL (lines 1 - 33)	223,485	239,493	$ 2,784,022 *	$ 11.62	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 7,780	1-3	35
36	Medical Director	O	500	9-3	36
37	Medical Records Consultant	N	2,392	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	2,950	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	6,875	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	4,651	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 32,348		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides		16,350	10-3	52
53	TOTAL (lines 50 - 52)		$ 16,350		53

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SAM BIBER	ADMIN	0	$ 10,849
SHERRY FICKENSCHER	ADMIN	0	31,986
LEE GODIN	ADMIN	0	15,752
KEVIN MEALS	ASST ADMIN	0	16,934
COLLEEN BOTTENS	ASST ADMIN	0	20,558
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,079

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CAREPLUS MGMT	DATA PROC	$ 14,400
CAREPLUS MGMT	ADMIN CONSULT	198,000
NATIONAL DATACARE	DATA PROC	662
AMERICAN DATA	DATA PROC	3,000
KBKB	ACCT	24,900
MEYER MAGENCE	LEGAL	4,681
KEANE & KEANE	LEGAL	6,500
CSC	LEGAL	265
PERSONNEL PLANNERS	UNEMPL CONSULT	1,907
RICHARD PEELO	M/C COST REPORT	3,750
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 258,065

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,268
Unemployment Compensation Insurance	35,906
FICA Taxes	210,671
Employee Health Insurance	88,238
Employee Meals	15,002
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	2,978
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	30,312
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 438,375

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	22,737
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	8,857
TRUST FEES/CONTRIBUTIONS/ETC	3,155
MGMT CO ALLOCATION	5,082
DUES & SUBSCRIPTIONS	7,355
LICENSES & PERMITS	4,279
TRUST FEES/CONTRIBUTIONS/ETC	(3,155)
Less: Public Relations Expense	(0)
Non-allowable advertising	(7,666)
Yellow page advertising	(1,141)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,503

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOCATION	587
Seminar Expense	
	885
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,472

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	2000	$ 2,070	3	$	$	$ 345	$ 690	$ 690	$ 345	$	$	$
2	PAINT/DECORATING	2001	2,847	3				475	949	949	474		
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 4,917		$	$	$ 345	$ 1,165	$ 1,639	$ 1,294	$ 474	$	$

Facility Name & ID Number OAK PARK HEALTHCARE CENTER # 0044602 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE 6,383**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,552** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **111,690**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **15,002** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: OAK PARK HEALTHCARE CENTER #0044602 **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,780	
	REPAIRS & MAINTENANCE		6,467	
			0	14,247
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		48,367	
	ELECTRICITY		51,913	
	WATER		32,206	
	CABLE TV - LOBBY		0	
			0	132,486
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,116	
	PAINTING & DECORATING		2,847	
	BUILDING REPAIRS		3,297	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		16,040	
	ELEVATOR MAINTENANCE & REPAIR		10,582	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,750	
	FIRE SERVICE		4,515	
			0	
			0	
			0	44,147
7	**OTHER**			
	SCAVENGER		12,815	
	SECURITY SERVICE		59	12,874
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	500	500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	16,350	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,392	
	PHARMACY CONSULTANT	XVIII B 39-2	2,950	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL SERVICES		6,237	
			0	27,929
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		8,658	
	SPEECH THERAPY SERVICES		675	
	OCCUPATIONAL THERAPY SERVICES		7,612	
	THERAPY CONTRACT SERVICES		9,360	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	7,200	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	6,875	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	40,380
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,651	
			0	4,651
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number OAK PARK HEALTHCARE CENTER **#0044602** **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		133	133
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	18,062	
	ADMINISTRATIVE CONSULTANTS	XIX C	198,000	
	PROFESSIONAL FEES	XIX C	42,003	
			0	258,065
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	7,666	
	EMPLOYEE WANT ADS	XIX F	22,737	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	7,355	
	LICENSES & PERMITS	XIX F	4,279	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	50	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,141	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	256	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,899	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	46,383
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		0	
	EQUIPMENT REPAIR & MAINTENANCE		8,190	
	OUTSIDE CLERICAL SERVICES		122,400	
	PENALTIES / OVERDRAFT CHARGES	VI 18	25,417	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		1,062	
	TELEPHONE		22,234	
	MESSENGER SERVICE		415	
			0	179,718

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	210,671	
	UNEMPLOYMENT COMPENSATION	XIX D	35,906	
	WORKERS COMPENSATION INSURANC	XIX D	55,268	
	HOSPITALIZATION INSURANCE	XIX D	88,238	
	EMPLOYEE BENEFITS - OTHER	XIX D	2,978	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	30,312	
	CHICAGO HEAD TAX	XIX D	0	423,373
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	885	
	TRAVEL	XIX G	0	
			0	
			0	885
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		66	66
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		110,611	110,611
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,296,448

OAK PARK HEALTHCARE CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	253,743
LESS SALES TAX	(819)
NET FOOD	252,924
TOTAL PATIENT CENSUS	57,718
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	173154
ADD # EMPLOYEE MEALS/DAY	30
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	10950

PATIENT MEALS	173154
ADD EMPLOYEE MEALS	10950
TOTAL MEALS/YEAR	184104
NET FOOD	252924
DIVIDE TOTAL MEALS/YEAR	184104
COST PER MEAL	1.37
TIME EMPLOYEE MEALS	10950
EMPLOYEE MEAL RECLASSIFICATION	15002